wisconsin Medicaid update and BadgerCare

February 2004 ● No. 2004-10

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Intensive In-Home Treatment Providers

HMOs and Other Managed Care Programs

Revisions to Prior Authorization Request Form (PA/RF) instructions for intensive in-home treatment providers

Revision of instructions

Wisconsin Medicaid is revising Elements 3 and 15 of the Prior Authorization Request Form (PA/RF) instructions for intensive in-home treatment providers, which were published in the July 2003 *Wisconsin Medicaid and BadgerCare Update* (2003-74), titled "Changes to local codes, paper claims, and prior authorization for intensive in-home treatment, a HealthCheck 'Other Service,' as a result of HIPAA." The revised instructions for these elements are as follows:

- Element 3 — Processing Type. Enter processing type "126" — Psychotherapy.
- Element 15 — Performing Provider Number. Enter the eight-digit Medicaid provider number of the certified psychotherapist.

Refer to Attachments 1 and 2 of this *Update* for revised instructions for the PA/RF and a revised sample PA/RF.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Prior Authorization Request Form (PA/RF) Completion Instructions for intensive in-home treatment services

(For claims submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type "126" — Psychotherapy.

Element 4 — Billing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the certified psychotherapist.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service requested.

Element 17 — Modifiers
Enter the two modifiers that correspond to the procedure code listed.

Element 18 — POS
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate procedure code for services.

Element 20 — QR
Enter the appropriate quantity (e.g., number of units) requested for the procedure code listed.

Element 21 — Charge
Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charge
Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 2
Sample Prior Authorization Request Form (PA/RF) for intensive in-home treatment services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Wilson** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**126**
	4. Billing Provider's Medicaid Provider Number **56781234**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A	☒ M ☐ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
313.81 - oppositional disorder		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
N/A	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
12345678	**H0004**	**HA**	**HO**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**52**	**XXX.XX**
12345678	**H0004**	**HA**	**HN**			**12**	**Behavioral health counseling and therapy, per 15 minutes**	**104**	**XXX.XX**
12345678	**99082**	**HA**	**HO**			**99**	**travel**	**13**	
12345678	**99082**	**HA**	**HN**			**99**	**travel**	**26**	

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **X,XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

☐ Approved

Grant Date Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

SIGNATURE — Consultant / Analyst Date Signed